

BAY CHIROPRACTIC

CONFIDENTIAL TODDLER (ages 2 – 5) PATIENT HISTORY FORM

Sex:		First name:		Surname:	
Address:					
Suburb:		State:		Postcode:	
Mother's Name:		MO:		PH:	
Father's Name:		MO:		PH:	
Date of Birth:	/ /	Age:		Private Health Fund Name?	
Best Contact Email address:					
Who recommended you to our Practice?					
Has child seen a chiropractor before?	Yes / No	When was last treatment?			
What is the main reason for attending this chiropractic clinic?					
Has your child had treatment for this complaint before?					
<u>BIRTH DETAILS:-</u> Please Circle.					
Any problems requiring treatment at birth?					
Type of Delivery?	Normal / Breech / Forceps / Caesarean / Suction				
Head Shape at Birth?	Normal / Asymmetric	Premature?	Yes / No	Immunised?	Yes / No
Blood Group?		Number of siblings?			
Allergies?					
<u>DEVELOPEMENT DETAILS:-</u>					
Crawling Age?		Walking Age?			
<u>GENERAL HEALTH:-</u> Please Circle.					
Crying Patterns?	GOOD / FAIR	Sleep Patterns?	GOOD / FAIR	Appetite?	GOOD / FAIR
Activity & Energy Levels?	GOOD / FAIR	Immune System?	GOOD / FAIR		
Is your child taking any medication? Please list:					
.....					

<p>Has your child taken any long-term medication in the past? Please list:</p> <p>.....</p>		
<p>Has your child ever been to hospital or had any surgery? Please give details:</p> <p>.....</p> <p>.....</p>		
<p>Family History?</p> <p>.....</p> <p>.....</p> <p>.....</p>		
<p>Have you noticed your baby has problems with any of the following:- Please Circle.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> Headaches / Fever Ear Problems / Hearing Eye Problems Nose / Sinus / Hayfever / Allergies Mouth Problems / Throat Infections / Teething Respiratory Infections / Asthma / Breathing Problems New or Recurrent Cough Bones or Joint Pain / Growth & Development Psychological / Behavioural / Attention / Seizures Speech Problems </td> <td style="width: 50%; vertical-align: top;"> Tantrums / Nightmares / Difficulty Settling Discomfort with Neck / Head Held to One Side Skin Conditions Lumps / Swellings / Bruising Gastrointestinal / Abdominal Discomfort / Reflux Vomiting / Diarrhoea / Constipation / Digesting Food Genital Problems Urinary Problems / Bedwetting Heart Problems Muscle Control / Lack of Muscle Tone / Balance & Co-ordination </td> </tr> </table>	Headaches / Fever Ear Problems / Hearing Eye Problems Nose / Sinus / Hayfever / Allergies Mouth Problems / Throat Infections / Teething Respiratory Infections / Asthma / Breathing Problems New or Recurrent Cough Bones or Joint Pain / Growth & Development Psychological / Behavioural / Attention / Seizures Speech Problems	Tantrums / Nightmares / Difficulty Settling Discomfort with Neck / Head Held to One Side Skin Conditions Lumps / Swellings / Bruising Gastrointestinal / Abdominal Discomfort / Reflux Vomiting / Diarrhoea / Constipation / Digesting Food Genital Problems Urinary Problems / Bedwetting Heart Problems Muscle Control / Lack of Muscle Tone / Balance & Co-ordination
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PARENT / GUARDIAN INFORMATION PRIOR TO TREATMENT

Changes to the law now require all practitioners who manipulate the spine to warn patients of the material risks. In extremely rare circumstances, it is possible to exacerbate a condition. All techniques employed are gentle and safe, and manipulations on children are provided with extreme care.

Chiropractic adjustments (manipulation) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993).

If you have any questions relating to the treatment your child is about to receive, please speak to the chiropractor. If you understand the above information and give your consent to treatment please sign below.

Parent / Guardian Signature: **Date:** / /